§6013. Claim Handling Procedures

A. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of various claim submissions. Health insurance issuer claim handling procedures shall be filed with the Office of Health Insurance for review and approval. Such procedures shall include:

1. a process for documenting the date of actual receipt of claims. Health insurance issuers shall include appropriate safeguards to assure claims are appropriately classified and directed to the appropriate claims staff for review. The procedures shall include a process for documenting complaints regarding lost claims and appropriate corrective action protocols;

2. a process for reviewing claims for accuracy and acceptability. Health insurance issuers shall document their review process that includes procedures to verify compliance with uniform claim handling procedures. The procedures shall document the reasonable period of time taken to completely review each claim for completeness. The process and average timeframe utilized by the health insurance issuer shall be described in sufficient detail to document the average time required to determine if a uniform claim form has been correctly completed. For any claim that is found to be incomplete or otherwise not payable, the health insurance issuer shall provide specific written notice to the claimant within two days of all known reasons that the claim cannot be processed for payment within a reasonable period of time from the date of reviewing such claim for completeness. The procedures shall assure that the health insurance issuer prohibits the offsetting of claim payments for any other party, except as specifically provided by law, or with the expressed written consent of the claimant or by the contracted medical services provider contract. Except as required under R.S. 40:2010, a health insurance issuer whose policies or contracts of coverage do not allow benefit assignment shall be authorized to reject claims that are incorrectly completed as assigned claims;

3. a process for reporting all claims rejected by the health insurance issuer and the reason for such rejection.

B. Late Payment Procedures. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any claimant who is not paid within the time frames specified in this regulation receives a late payment adjustment equal to 1 percent of the amount due at the time the claim is paid. For any period greater than 25 days following the time frames specified in this regulation, the health insurance issuer shall pay to the claimant an additional late payment adjustment equal to 1 percent of the unpaid balance due for each month or partial month that such claim or any portion of the claim remains unpaid.

C. Compliant Procedures. The health insurance issuer's procedures shall include a process for insureds or enrollees to file complaints regarding provider demands for amounts owed by health insurance issuers. The procedures shall include all actions that will be taken by the health insurance issuer to address non-compliant providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6015. Limitations on Claim Filing and Audits

A. Health insurance issuers that limit the period of time that a claim may be filed for payment of benefits shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims. For example, where a health insurance issuer limits the period for filing a claim for benefits to 12 months, then the health insurance issuer shall be limited to 12 months from the date of payment to perform any review or audit of the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6017. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2009 (September 2000).

Chapter 61. Regulation 16C Investment by Insurers of Part of Premium Paid, Return Guaranteed

§6101. Policy Directive Number Three to Insurance Companies

A. Effective January 1, 1959, no life insurance policy will be approved for use in the state of Louisiana, which does not guarantee to the policyholder or his or her beneficiary a return of all money, in excess of that part of the gross premium charged for life and disability insurance protection plus any guaranteed coupons, that is, any amount in excess of the net tabular premium, plus the loading for guaranteed coupons and expenses, which the policy provides shall be invested by the insurance company for the benefit of the policyholder, increased by the rate of interest stipulated in the contract.

B. Any policy which meets the above qualifications must also have printed on its first page, in prominent type, a brief description of all investment features.

C. Approval heretofore granted on all policies which do not comply with this directive, is hereby withdrawn, effective January 1, 1959, and all companies issuing such contracts are directed to cease issuing them within the state effective that date.

D. In order to assure compliance with this directive, all policies containing such investment features must be resubmitted together with all applicable sales promotion literature to be used therewith, to this office for new approval. Such policies will not be considered for approval in this state until the insurer submitting them furnishes evidence that such contracts have been approved in its domiciliary state.

E. This directive is not intended to apply to participating contracts of insurance whereby dividends are payable to a policyholder from divisible surplus of the company, nor to contracts. containing annual coupons the accrued maturity value of which are guaranteed payable to the policyholder upon lapse or withdrawal or to the beneficiary at death of the insured, unless these particular plans of insurance also contain investment features.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, October 1, 1958.

Chapter 62. Regulation 77C Medical Necessity Review Organizations

§6201. Purpose

A. The purpose of this regulation is to enforce the statutory requirements of Title 22 of the Louisiana Revised Statutes of 1950 that require health insurance issuers who seek to establish exception criteria or limitations on covered benefits that are otherwise offered and payable under a policy or certificate of coverage sold in this state, by requiring a medical necessity determination to be made by the health insurance issuer. The statutory requirements also apply to any health benefit plan that establishes exception criteria or limitations on covered benefits that are otherwise offered and payable under a non-federal government benefit plan. Additionally, the statute establishes a process for Medical Necessity Review Organizations to qualify for state licensure and Independent Review Organizations to become certified by the Department of Insurance. The statutory requirements establish the intent of the legislature to assure licensed health insurance issuers and non-federal government benefit plans meet minimum quality standards and do not utilize any requirement that would act to impinge on the ability of insureds or government employees to receive appropriate medical advice and/or treatment from a health care professional. This regulation has no effect on the statutory requirements of R.S. 22:657. Emergency medical conditions as defined in R.S. 22:657 shall be covered and payable as provided therein.

B. This regulation implements the statutory requirements of R.S. §§22:2021, and Chapter 7 of Title 22 of the Louisiana Revised Statutes regarding the use of medical necessity to limit stated benefits in a fully insured health policy or HMO certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:844 (April 2002).

§6203. Definitions

Adverse Determination a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Ambulatory Review a review of health care services performed or provided in an outpatient setting.

Appropriate Medical Information all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include, but are not necessarily limited to, one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity:

1. admission history and physical examination report;
2. physician's orders;
3. progress notes;
4. nursing notes;
5. operative reports;
6. anesthesia records;
7. hospital discharge summary;
8. laboratory and pathology reports;
9. radiology or other imaging reports;
10. consultation reports;
11. emergency room records; and
12. medication records.

Authorized Representative a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. *Authorized representative* may include the covered person's treating provider, if the covered person appoints the provider as his authorized representative and the provider agrees and waives in writing, any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary by the MNRO/IRO, and the covered person or his authorized representative thereafter requests the services, nothing shall prohibit the provider from charging the provider's usual and customary charges for all MNRO/IRO determined non-medically necessary services provided when such requests are in writing.

Case Management a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.